MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11203 — 11173 — Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural R#60 Hagerstown
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): None

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Penna — b. COUNTY: York
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Felton 75 x 3
d. STREET ADDRESS: R # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Albert Andrew — Last: Amsbaugh
4. DATE OF DEATH: Month: Oct. — Day: 20 — Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 11, 1895
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Molder
10b. KIND OF BUSINESS OR INDUSTRY: Foundry & Chain Co.
11. BIRTHPLACE (State or foreign country): Penna
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 176-01-6242
17. INFORMANT — Address: Mrs. Pauline E. Bombell- 1601 Va Ave Hagerstown, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Crushed chest — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Bone Deep Laceration across rt knee
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Closed fractured rt femur

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Head-on automobile collison
20c. TIME OF INJURY: Hour: 4:15 p. m. — Month, Day, Year: Oct. 20 1957
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town) (County) (State): Rural Hagerstown Wash Md

21. I certify that I taak charge af the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Hamicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Oct. 21, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/23/57
22c. NAME OF CEMETERY OR CREMATORY: Greenmount Cem.
22d. LOCATION (City, town, or county) (State): York, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: W. J. Normant — ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR — DATE: Oct. 23, 1957
24b. REGISTRAR'S SIGNATURE: Thos. H. Bowers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11174

11163

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 10 YRS.
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MATYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 70[illegible] E. ANTIETAM ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ETHEL — Middle: LORRAINE — Lost: BAKER

4. DATE OF DEATH: Month: OCT. — Day: 7 — Year: 19 57

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 9/24/1913

9. AGE (In years last birthday): 44 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SEAMSTRESS

10b. KIND OF BUSINESS OR INDUSTRY: DRESS CO.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLAM BAKER

14. MOTHER'S MAIDEN NAME: MARY C. REED

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 561-38-6370

17. INFORMANT: MRS. OTTIE CRILLEY — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiovascular Collapse. — INTERVAL BETWEEN ONSET AND DEATH: min

331x

DUE TO (b): Cerebral Vas. Accident — 5 hrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Arteriosclerosis — yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): no

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): no.

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-27-56, 19____, to 10-7-57, 19____, that I last saw the deceased alive on 10-7-57, 19____, and that death occurred at 5 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Louis G. Graff M.D. — ADDRESS (Street, city or town, state): 119 E. Antietam — DATE SIGNED: 10-7-57

PHYSICIAN'S NAME (Type): Louis G. GRAFF M.D. Hagerstown, (W.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10/9/57

22c. NAME OF CEMETERY OR CREMATORY: GREENWAY CEM.

22d. LOCATION (City, town, or county) (State): BERKLEY SPRINGS W. VA.

23. FUNERAL DIRECTOR'S SIGNATURE: W. J. Norment — ADDRESS: Hagerstown, Md

24a. REC'D BY REGISTRAR DATE: Oct. 9 1957

24b. REGISTRAR'S SIGNATURE: Chas H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11204

CERTIFICATE OF DEATH

11175

Reg. Dist. No. 303

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown R.F.D.

c. LENGTH OF STAY IN 1b: 2 months

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Gateway Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Washington

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown

d. STREET ADDRESS: 1208 Pope Ave.,

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Welty; Middle: ; Last: Baker Sr.

4. DATE OF DEATH: Month: 10; Day: 19; Year: 19 57

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 23, 1877

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10b. KIND OF BUSINESS OR INDUSTRY: Furnace Tender

11. BIRTHPLACE (State or foreign country): Wash. Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Baker

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-05-6223

17. INFORMANT: Welty Baker Jr. Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Chr. Endocarditis — 4 mo.

DUE TO

(c)

491x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb'ry 1, 1957 to Oct 19, 1957, that I last saw the deceased alive on Oct 19, 1957, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: David R. Brewer M.D. ADDRESS (Street, city or town, state): Clear Spring Md DATE SIGNED: 10/21/57

PHYSICIAN'S NAME (Type): David R. Brewer

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 10-22-57

22c. NAME OF CEMETERY OR CREMATORY: Manor

22d. LOCATION (City, town, or county): Tilghmanton (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Fred W. Kraiss ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: Oct-25-57

24b. REGISTRAR'S SIGNATURE: Leroy M Forkler (Deputy)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely [illegible] in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr.E.W.Ditto,Jr. 11164

CERTIFICATE OF DEATH

11176

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 30 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 870 Frederick St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 870 Frederick St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle ARTHUR — Last BARBER

4. DATE OF DEATH: Month October — Day 22 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Janu.29,1885

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintence

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hagerstown,Wash.Co.Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas H. Barber

14. MOTHER'S MAIDEN NAME: Florentine Arthur

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - - - - - -

16. SOCIAL SECURITY NO.: 220-16-3638

17. INFORMANT — Address: Mrs.Florentine Barber-870 Frederick St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 30 min
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic heart disease — 10 yrs
DUE TO
(c):

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 30, 1957, to Oct 23, 1957, that I last saw the deceased alive on Oct 16, 1957, and that death occurred at 8:15 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ew Ditto Jr, M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-24-57
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman-Hagerstown, Maryland

24a. REC'D BY REGISTRAR: Oct.25/1957

24b. REGISTRAR'S SIGNATURE: Chas H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11205 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 11-177 D6

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for [redacted] files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the re[redacted] or prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural 2 Hancock Md
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Home

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Rural 2 Hancock Maryland.
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Russell — Middle: — Last: Barnhart

4. DATE OF DEATH: Month: 10 — Day: 28 — Year: 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 4.22.1909

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR: Months: 6 — Days: 6
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Orchard

11. BIRTHPLACE (State or foreign country): Washington Mennty Md

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Harry Barnhart

14. MOTHER'S MAIDEN NAME: Bessie Seal

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 207-01-5999

17. INFORMANT Address: Lillian P Eddie 237 Penna.Ave Hancock Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Burns - Charring of head, entire body, upper and lower extremities
E916.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ **or CONTRIBUTING** ☐ **CAUSE OF DEATH.**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Burned when trailer caught afire

20c. TIME OF INJURY Hour: 10: p.m. Month, Day, Year: Oct. 28 1957

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home

20f. (City or town) (County) (State): Rural Hancock Wash Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11-1-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11.3.57

22c. NAME OF CEMETERY OR CREMATORY: Orchard Ridge Cemetery

22d. LOCATION (City, town, or county) (State): Near Hancock Washington Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Howard P Stone Hancock md

24a. RECD BY REGISTRAR DATE: 11/1/57

24b. REGISTRAR'S SIGNATURE: J A Keller

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr.Brewer 11206 **CERTIFICATE OF DEATH** 11178 302

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown-RFD
c. LENGTH OF STAY IN 1b: 6 months
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Gateway Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Clearspring, Md.
d. STREET ADDRESS: 1 Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARTHA Middle ELIZABETH Lost BARTLE

4. DATE OF DEATH: Month October Day 14, Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 20,1863
9. AGE (In years last birthday): 94 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Clearspring,Wash.Co.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter Mousa
14. MOTHER'S MAIDEN NAME: Mary Baer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): - - - -
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Ernest L.Bartle-341 Mealy Pkwy.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arterio Sclerotic Heart Dis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.
4.20.0
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1952 to Oct 15, 1957, that I last saw the deceased alive on Oct 14, 1957, and that death accurred at 6.50 M, from the causes and an the date stated abave.

ACTUAL SIGNATURE: David R. Brewer M.D. — ADDRESS (Street, city or town, state): Clear Spring Md — DATE SIGNED: 10/15/57

PHYSICIAN'S NAME (Type): David R. Brewer Clear Spring Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-16-57
22c. NAME OF CEMETERY OR CREMATORY: St. Michaels Cath. Ceme.-Clearspring, Md.
22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman*Hagerstown, Maryland
24a. REC'D BY REGISTRAR DATE: OCT 17 1957
24b. REGISTRAR'S SIGNATURE: Chas H Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pa and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11179

11207

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLEAR SPRING
c. LENGTH OF STAY IN 1b: I2 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: I05 CUMBERLAND ST

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 CLEAR SPRING
d. STREET ADDRESS: I05 CUMBERLAND ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GRANVILLE — Middle N. — Last BAUBLITZ

4. DATE OF DEATH: Month IO — Day I5 — Year 19 57

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUG. I7, I898

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MERCHANT

10b. KIND OF BUSINESS OR INDUSTRY: VARIETY STORE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: NELSON BAUBLITZ

14. MOTHER'S MAIDEN NAME: MARY MORAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 300-18-1045

17. INFORMANT: MRS. MARY L. BAUBLITZ — Address: CLEAR SPRING, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): VENTRICULAR FIBRILLATION — INTERVAL BETWEEN ONSET AND DEATH: 5 MINUTES
420.1
DUE TO (b): CORONARY ARTERY OCCLUSION WITH MYOCAROIAL INFARCTION — 2 HOURS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): CORONARY ARTERY ATHEROSCLEROSIS — 3 YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MAY 24, 1954, to OCTOBER 15, 19 57, that I last saw the deceased alive on OCTOBER 15, 1957, and that death occurred at 10-45PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Archie Robert Cohen M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED:

PHYSICIAN'S NAME (Type): ARCHIE ROBERT COHEN, M.D. — CLEAR SPRING, MARYLAND — OCTOBER 16, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: IO/I8/57
22c. NAME OF CEMETERY OR CREMATORY: ST. PAULS
22d. LOCATION (City, town, or county) (State): WASHINGTON CO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John F. Clark
ADDRESS: Clear Spring, Md.

24a. REC'D BY REGISTRAR DATE: 10/18-57
24b. REGISTRAR'S SIGNATURE: Joseph W. Murray

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11208

CERTIFICATE OF DEATH

11180

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Hagerstown #5

c. LENGTH OF STAY IN 1b: 6 Years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x1 Rural, Hagerstown #5

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d. STREET ADDRESS: 1

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Carroll — Middle: Ritchie — Last: Belew

4. DATE OF DEATH: Month: Oct. — Day: 28, — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/9/1947

9. AGE (In years last birthday): 10 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Waynesboro Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Claude T. Belew

14. MOTHER'S MAIDEN NAME: Clara J. Lauhoff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Claude T. Belew — Address: Hagerstown Md., #5

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): myocarditis, acute — — INTERVAL BETWEEN ONSET AND DEATH: 1-2 days
754.4
DUE TO (b): URI — 3-4 days.
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (c): Congenital Heart Lesion ? — Both —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 20 APRIL, 1954 to 28 OCT., 1957, that I last saw the deceased alive on 27 Oct., 1957, and that death occurred at 1:12 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Harry Hyoungs M.D. — ADDRESS (Street, city or town, state): Blue Ridge Summit Pa — DATE SIGNED: 29 Oct 1957

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/30/57

22c. NAME OF CEMETERY OR CREMATORY: Green Hill

22d. LOCATION (City, town, or county) (State): Waynesboro, Franklin Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Walter Y Grove — ADDRESS: Waynesboro Pa

24a. REC'D BY REGISTRAR: Oct. 31. 1957

24b. REGISTRAR'S SIGNATURE: Chas H Boewer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11209

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11181

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Funkstown Legion Home
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 307 Radcliff Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William George — Middle: Earl — Last: Bennight, Sr.

4. DATE OF DEATH: Month: Oct. — Day: 19 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-11p - 1918

9. AGE (In years last birthday): 39 yrs.

IF UNDER 1 YEAR: Months: 9 — Days: 8
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blueprint Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: FairchildAircraft

11. BIRTHPLACE (State or foreign country): Henryetta Okla.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Tollie T. Bennight

14. MOTHER'S MAIDEN NAME: Dean Johnston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 444-12-8672

17. INFORMANT: Address: Mrs. Wm. G. E. Bennight Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH:
420.1
DUE TO (b): advanced arteriosclerotic coronary heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. none

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY: Hour: a. m. p. m. none — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town): - (County): - (State): -

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Oct. 19'57

EXAMINER'S NAME (Type): S. Robert Wells, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-22-1957
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home
R. Franklin Rouzer
ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR: Oct. 25, 1957
24b. REGISTRAR'S SIGNATURE: Chas. H. Boerner

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11210

CERTIFICATE OF DEATH

Reg. Dist. No. 11182 304

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hancock
c. LENGTH OF STAY IN 1b: 3 WKS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Hancock Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hancock x2
d. STREET ADDRESS: 110 Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emory — Middle: McClung — Last: Booth

4. DATE OF DEATH: Month: 10 — Day: 28 — Year: 19 57

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9.19.1887

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months: 1 — Days: 9
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machanist

10b. KIND OF BUSINESS OR INDUSTRY: Celenese Corp

11. BIRTHPLACE (State or foreign country): Fulton County Penna

12. CITIZEN OF WHAT COUNTRY? U.S.A?

13. FATHER'S NAME: William Booth

14. MOTHER'S MAIDEN NAME: Rachael Fisher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-10-5342A

17. INFORMANT: Mrs Mary E Booth — Address: Hancock Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 minutes
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Mitral Stenosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-2-3, 1957, to 10-28, 1957, that I last saw the deceased alive on 10-25, 1957, and that death occurred at 9:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Herbert R. Tobias M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type): Herbert R. Tobias — Berkeley Springs, W.Va.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10.30.57
22c. NAME OF CEMETERY OR CREMATORY: Presbyterian Cemetery
22d. LOCATION (City, town, or county) (State): Warfordsburg Fulton Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard F Hose — ADDRESS: Hancock md

24a. REC'D BY REGISTRAR DATE: 12/9/57
24b. REGISTRAR'S SIGNATURE: J A Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11211 **CERTIFICATE OF DEATH** Reg. Dist. No. 11183

1. PLACE OF DEATH
a. COUNTY: Washingtom — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Smithsburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Smithsburg X2
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Emory — Middle: David — Last: BOWMAN

4. DATE OF DEATH: Month: Oct. — Day: 24. — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Dec.23.1897

9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David E. Bowman

14. MOTHER'S MAIDEN NAME: Julia A. Tracey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 191-26-6840

17. INFORMANT: Address: Annie R.Bowman Smithsburg R.D.1 MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	URIEMIA	6 WEEKS
442X DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	NEPHROSclerosis	1 YEAR
DUE TO (c)	HYPERTENSIVE CARDIOVASCULAR-RENAL Disease	5 YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-29-57, 19____, to 10-23-57, 1957, that I last saw the deceased alive on 10-23-57, 19____, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ross S. Funch M.D. — ADDRESS (Street, city or town, state): 1176 W. Main St. Waynesboro Pa. — DATE SIGNED: 10-20-57

PHYSICIAN'S NAME (Type): Ross S. FUNCH M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-27-57

22c. NAME OF CEMETERY OR CREMATORY: Pleasant Valley Cem.

22d. LOCATION (City, town, or county) (State): near Smithsburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond E. Creager — ADDRESS: Thurmont, Md.

24a. REC'D BY REGISTRAR DATE: OCT 29 '57

24b. REGISTRAR'S SIGNATURE: W. H. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

. 11165

CERTIFICATE OF DEATH

11184

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 333 Bryan Place

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 333 Bryan Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA Middle Lost BRILL

4. DATE OF DEATH: Month October Day 21 Year 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 13,1873

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months 11 Days 8
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress

10b. KIND OF BUSINESS OR INDUSTRY: Laundry

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Brill

14. MOTHER'S MAIDEN NAME: Anna Suter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-4818

17. INFORMANT: Mrs. Harold Fuller Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse — INTERVAL BETWEEN ONSET AND DEATH: Min.

422.1

DUE TO (b) Arteriosclerosis — Yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Debilitation — Yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible], 19__, to Oct, 19__, that I last saw the deceased alive on Oct, 19__, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Louis G. Graff M.D. ADDRESS (Street, city or town, state): 119 E. Antietam St. DATE SIGNED: 10/21/57

PHYSICIAN'S NAME (Type): Louis G. GRAFF Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/23/1957

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home R. Franklin Rouzer ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR: Oct 23/1957

24b. REGISTRAR'S SIGNATURE: Chas. H. Boerner

1

Countersigned 11166 S. Robert Wells M.D. BME 11-6-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11185

Reg. Dist. No. 702

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 48 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 149 King St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 149 King St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: Low — Last: Carnochan Sr.

4. DATE OF DEATH: Month: Oct — Day: 31 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 18, 1889

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Box Co.

11. BIRTHPLACE (State or foreign country): Near Chillicothe Ohio

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John A. Carnochan

14. MOTHER'S MAIDEN NAME: Marian Low

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 705-10-7901

17. INFORMANT: John L. Carnochan Jr. Address: Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 hours,
DUE TO (b): Arteriosclerotic heart disease — unknown.
DUE TO (c):

420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on Never saw him Alive, 19____, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard T. Binford, M.D. — ADDRESS (Street, city or town, state): 1135 Potomac Ave. Hag. Md. — DATE SIGNED: 11 Nov 57

PHYSICIAN'S NAME (Type): Richard T. Binford

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-2-57

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son — ADDRESS: Hagerstown Md.

24a. REC'D BY REGISTRAR DATE: Nov 7 1957

24b. REGISTRAR'S SIGNATURE: Edith Boerner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

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2

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11212

Reg. Dist. No. 11186

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Near Cavetown
c. LENGTH OF STAY IN 1b: 12 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Stone Quarry

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smithsburg XO
d. STREET ADDRESS: 68 W. Water St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ronald; Middle: Terry; Last: Cowan
4. DATE OF DEATH: Month: Oct. Day: 13, Year: 1957

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 25, 1935
9. AGE (In years last birthday): 22 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): office mach. opr.
10b. KIND OF BUSINESS OR INDUSTRY: aircraft ind.
11. BIRTHPLACE (State or foreign country): Greencastle, Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Earl O. Cowan
14. MOTHER'S MAIDEN NAME: Ann Catherine Spessard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): Active-1957
16. SOCIAL SECURITY NO.: 214-30-1876
17. INFORMANT: Address: Earl O. Cowan, Smithsburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractured Skull (open) — INTERVAL BETWEEN ONSET AND DEATH: 15 min.
978X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Jumped about 100 feet into stone quarry
20c. TIME OF INJURY: Hour XXX 9:45 p. m. Month, Day, Year: Oct. 13 1957
20d. INJURY OCCURRED: White at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Stone Quarry
20f. (City or town) (County) (State): Rural Smithsburg, Wash Md

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10-15-57

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 10-16-57
22c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery
22d. LOCATION (City, town, or county) (State): Smithsburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: ADDRESS: Scott F. Minnich & Son, Smithsburg, Md.
24a. REC'D BY REGISTRAR: DATE: OCT 18 '57
24b. REGISTRAR'S SIGNATURE: Alice Leach

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with Local Registrar, State Board of Health, or designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

. 11167

CERTIFICATE OF DEATH

Reg. Dist. No. 11187 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 50 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 112 Randolph Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 112 Randolph Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNIE Middle LYDIA Last DAVIS

4. DATE OF DEATH: Month October Day 18 Year 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 14, 1871
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Keedysville, Wash. Co. Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hiram Snyder
14. MOTHER'S MAIDEN NAME: Lucinda Gouff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): — — — —
16. SOCIAL SECURITY NO.: 212-14-7014
17. INFORMANT: J. Franklin Davis
Address: 112 Randolph Av.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arterio sclerotic heart disease with — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs +
420.0
DUE TO (b): Myocardial failure
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 260x Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 15, 1947, to 18 Oct, 1957, that I last saw the deceased alive on 18 Oct, 1957, and that death occurred at 1:15 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: F F Lusby M.D. ADDRESS (Street, city or town, state): 230 N Potomac St Hagerstown Md DATE SIGNED: 18 Oct 57
PHYSICIAN'S NAME (Type): F. F. Lusby

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-21-57
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown, Wash. Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman—Hagerstown, Maryland
24a. REC'D BY REGISTRAR DATE: OCT 23 1957
24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and signed in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11168

CERTIFICATE OF DEATH

11188

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Garlock Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 118 W. Magnolia Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: Edward — Last: Davis

4. DATE OF DEATH: Month: October — Day: 26 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 15, 1871

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plasterer

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Hagerstown Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Leonard Davis

14. MOTHER'S MAIDEN NAME: Emma J. Palmer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): 0---
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ---

17. INFORMANT: Mrs. C. R. Burger — Address: Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: appx 3 mo.
199.9
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/5/57, 19___, to 10/26/, 1957, that I last saw the deceased alive on 10/25/57, 19___, and that death occurred at 6:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: D Boyer M.D.
ADDRESS (Street, city or town, state): 135 N. Potomac Hag. Md.
DATE SIGNED: 10/26/57
PHYSICIAN'S NAME (Type): Dr. David J. Boyer

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-28-57
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Scott F. Minnich & Son Hag. Md.

24a. REC'D BY REGISTRAR DATE: Oct. 29 1957
24b. REGISTRAR'S SIGNATURE: Grant Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11169

CERTIFICATE OF DEATH

11189

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 900 Pennsylvania Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: E — Last: Dodson

4. DATE OF DEATH: Month: Oct. — Day: 14 — Year: 1957

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 12, 1887

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Christopher A. Nichols

14. MOTHER'S MAIDEN NAME: Fannie (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): nO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: M.H. Dodson Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: 1 day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/13/57, 19__, to 10/14/57, 19__, that I last saw the deceased alive on 10/14/57, 19__, and that death occurred at 9:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph L. Young M.D. — ADDRESS (Street, city or town, state): Williamsport, Md — DATE SIGNED: 10/17/57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 10-17-57

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Fred W. Kraiss Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: Oct. 17. 1957

24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely executed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr.G.LeVan 11213 **CERTIFICATE OF DEATH** 11190

Reg. Dist. No. 305

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boonsboro
c. LENGTH OF STAY IN 1b: 1½ yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Reeder Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ×2 Hagerstown R#1
d. STREET ADDRESS: 1 Beaver Creek
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK Middle LESLIE Last DOUB

4. DATE OF DEATH: Month October Day 31, Year 19 57

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct.10,1861
9. AGE (In years last birthday): 96 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miller
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Beaver Creek-Wash.Co.Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Philip R. Doub
14. MOTHER'S MAIDEN NAME: Cornelia Witmer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): — — — —
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: M. Berry Doub - Clearspring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

490 X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 17, 1957, to Oct 31, 1957, that I last saw the deceased alive on Oct 30, 1957, and that death occurred at 3 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G.W.LeVan M.D. ADDRESS (Street, city or town, state): Boonsboro DATE SIGNED: 11/1/57

PHYSICIAN'S NAME (Type): G.W.LeVan Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-2-57
22c. NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery
22d. LOCATION (City, town, or county) (State): Beaver Creek-Wash.Co.Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman-Hagerstown, Maryland
24a. REC'D BY REGISTRAR DATE: Nov.7.1957
24b. REGISTRAR'S SIGNATURE: John W. Bast

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11191

CERTIFICATE OF DEATH

11170

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 50 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 20 Summit Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First George Bittle Middle Last Entler

4. DATE OF DEATH: Month Oct. Day 20 Year 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 22, 1868

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): contractor

10b. KIND OF BUSINESS OR INDUSTRY: house building

11. BIRTHPLACE (State or foreign country): Shepherdstown, W.Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John P. Entler

14. MOTHER'S MAIDEN NAME: Amanda Hawn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT — Address: Mrs. Irene Hook, Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): General arteriosclerosis & Cerebral
DUE TO
331 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Thrombosis 3-4 yr. → Cerebral - Vascular
DUE TO
(c): Accident - (5 weeks)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Benign Prostatic hypertrophy

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 1, 1954, to Oct 20, 1957, that I last saw the deceased alive on Oct 20, 1957, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward W. Ditto III M.D. ADDRESS (Street, city or town, state): 217 W. Washington Street DATE SIGNED: 10/21/57

PHYSICIAN'S NAME (Type): Edward W. Ditto III, M.D. 217 W. Washington, Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 10-22-57

22c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery

22d. LOCATION (City, town, or county) (State): Shepherdstown, W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: Oct. 23 1957

24b. REGISTRAR'S SIGNATURE: Lohastt Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11171 — 11192 — Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 50 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 311 Jefferson Street

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 311 Jefferson Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Benjamin Franklin — Middle — Last Favorite

4. DATE OF DEATH: Month October — Day 14, — Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 23, 1872

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction Foreman

10b. KIND OF BUSINESS OR INDUSTRY: C & P Telephone

11. BIRTHPLACE (State or foreign country): Smithsburg, Wash Co.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jack Favorite

14. MOTHER'S MAIDEN NAME: Clara DeLosier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - -

16. SOCIAL SECURITY NO.: 212-05-0842

17. INFORMANT: Mrs. Mary F. Favorite — Address: 311 Jefferson St-

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO (b): Carcinoma prostate with metastasis to rt femur — ?
DUE TO (c): Multiple fractures of pelvic bones — 71 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Slipped and fell on the floor at home

20c. TIME OF INJURY — Hour 4 p. m. — Month, Day, Year: Aug. 4 1957

20d. INJURY OCCURRED — While at work ☐ — Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): at home

20f. (City or town) Hagerstown — (County) Wash — (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D. — DATE SIGNED

EXAMINER'S NAME (Type): S. Robert Wells, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

10-15-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-17-57
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Wash Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Andrew K. Coffman, — ADDRESS: Hagerstown Md.

24a. REC'D BY REGISTRAR — DATE: Oct 17 1957

24b. REGISTRAR'S SIGNATURE: Chas. H. Boovers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the [illegible] prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11172

CERTIFICATE OF DEATH

Reg. Dist. No. 302 11193

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 12 hrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Zullinger 75x-3
d. STREET ADDRESS: none
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle VIRGINIA Last FINAFROCK

4. DATE OF DEATH: Month October Day 2 Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 5, 1880

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months 11 Days 27
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Franklin Co. , Penn.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Knoll

14. MOTHER'S MAIDEN NAME: Julia Keefer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Knoll Finafrock Address: St. Thomas, Pennsylvania

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
332x
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchial Asthma

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1957, to Oct, 1957, that I last saw the deceased alive on 1 Oct, 1957, and that death occurred at 9:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G.W. Webster M.D. ADDRESS (Street, city or town, state): Greencastle Pa. DATE SIGNED

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/5/1957

22c. NAME OF CEMETERY OR CREMATORY: Norland Cemetery

22d. LOCATION (City, town, or county) (State): Chambersburg, Penn.

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home R. Franklin Rouzer ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR: Oct 2, 1957

24b. REGISTRAR'S SIGNATURE: Chas H Bowers

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Hirshman · 11173

CERTIFICATE OF DEATH

11194

Reg. Dist. No. 302

M

I

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 wks.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: Antietam Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle HUMERICHOUSE Last FISHER

4. DATE OF DEATH: Month Oct. Day 11, Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 28, 1869

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: - - - - -

11. BIRTHPLACE (State or foreign country): Md Kemps Mill-Wash. Co.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joel S. Fisher

14. MOTHER'S MAIDEN NAME: Louise Snyder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - - - -

16. SOCIAL SECURITY NO.: Unable to locate

17. INFORMANT: Mrs. Julia Spencer — Address: 242 E. Main St. Westminister, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fibro sarcoma - Generalized — INTERVAL BETWEEN ONSET AND DEATH: Months

420.0

DUE TO (b): Arteriosclerotic Heart Disease — Several yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): ____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 8, 1957, to Oct 11, 1957, that I last saw the deceased alive on Oct 10, 1957, and that death occurred at 1A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip J. Hirshman M.D. — ADDRESS (Street, city or town, state): 159 W. Washington St Hagerstown Md — DATE SIGNED: 10/12/57

PHYSICIAN'S NAME (Type): Philip J. Hirshman — 159 W. Washington St.-Hagerstown

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-13-57

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Wash. Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman-Hagerstown, Maryland

24a. REC'D BY REGISTRAR (Date): Oct 15, 1957

24b. REGISTRAR'S SIGNATURE: Chas H Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 FilmG222 11-4-57 et

11214

CERTIFICATE OF DEATH

11195

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown- rural
c. LENGTH OF STAY IN 1b: 1 yr.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Gate Way Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 28 Elizabeth St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rhoe — Middle: M I T, Ida — Last: Fox

4. DATE OF DEATH: Month: October — Day: 21, — Year: 19 57

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 12, 1868

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Wilhide

14. MOTHER'S MAIDEN NAME: Elmira (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Jesse Fox — Address: Thurmont, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arterial Sclerotic Cardiac Dis — INTERVAL BETWEEN ONSET AND DEATH: 1 year
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/30, 1956 to 10/21, 1957 that I last saw the deceased alive on 10/20, 1957, and that death occurred at 9:50 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: David R Brewer M.D. — ADDRESS (Street, city or town, state): Clear Spring Md — DATE SIGNED: 10/24/57

PHYSICIAN'S NAME (Type): David R Brewer

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-23-57

22c. NAME OF CEMETERY OR CREMATORY: United Brethern Cem.

22d. LOCATION (City, town, or county) (State): Thurmont, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Raymond E. Creager & Son Thurmont, Md.

24a. REC'D BY REGISTRAR DATE: OCT 25 1957

24b. REGISTRAR'S SIGNATURE: Chas H Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely executed in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11174 — Reg. Dist. No. 11196 — 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 9 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 243 N. Potomac Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 243 N. Potomac Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle GEARD — Last FRANKLIN

4. DATE OF DEATH: Month October — Day 13, ~~19~~ — Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 18, 1900
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months 9 Days 25
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Grocerman
10b. KIND OF BUSINESS OR INDUSTRY: own business
11. BIRTHPLACE (State or foreign country): Scranton, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isaac Franklin
14. MOTHER'S MAIDEN NAME: Mary Devers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-18-0798
17. INFORMANT: Mrs. Mary S. Franklin — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 705.4
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Lupus Erythematosus — INTERVAL BETWEEN ONSET AND DEATH: 6-56
DUE TO
(c): Coronary-arterio Heart Disease — 3 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-20-, 1956, to 10-13, 1957, that I last saw the deceased alive on 10-12-, 1957, and that death occurred at 7:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. W. Otto M.D. — ADDRESS (Street, city or town, state): Hagerstown Md — DATE SIGNED: 10/14/57

PHYSICIAN'S NAME (Type): L. W. Otto — Hagerstown Md — 10/14/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/17/1957
22c. NAME OF CEMETERY OR CREMATORY: St. Mark's Episcopal Cem.
22d. LOCATION (City, town, or county) (State): Lewisburg, Pennsylvania

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — P. Franklin Rouzer — ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR: Oct 16. 1957
24b. REGISTRAR'S SIGNATURE: Grace H Boerner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11197

11175

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 55 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 13 W. Baltimore St.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 13 W. Baltimore St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Joseph	A	Haines	Oct.	4	19 57

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white		Sept. 18, 1864	93 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired	W.M.R.R.	Uniontown, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Haines	Mary Blacksten

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	none	C. Wilbur Haines Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 191X Carcinoma of Face — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO: General arteriosclerosis — 10 yrs

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-1-57, 19____, to 10-4, 19 57, that I last saw the deceased alive on 10-2-57, 19 57, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. W. Deitz M.D. — ADDRESS (Street, city or town, state): Hagerstown Md — DATE SIGNED: 10/5/57

PHYSICIAN'S NAME (Type): A. W. Deitz — Hagerstown Md

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
burial	10-6-57	Rose Hill	Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Fred W. Kraiss Hagerstown, Md.	Oct. 7. 1957	Chas H Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11176 — Reg. Dist. No. 11198

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R # 5

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Hagerstown, Maryland
d. STREET ADDRESS: 1 R # 5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles — Middle Edward — Last Hause

4. DATE OF DEATH: Month October — Day 18 — Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 17, 1920

9. AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Aircraft Worker

10b. KIND OF BUSINESS OR INDUSTRY: Fairchilds

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: D. Randall Hause

14. MOTHER'S MAIDEN NAME: Nora French

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): World War #

16. SOCIAL SECURITY NO.: 2 217-16-2736

17. INFORMANT — Address: Mrs. June Bowman Hause - R#5 Hagerstown, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Rheumatic Fever — INTERVAL BETWEEN ONSET AND DEATH: 13 yrs
414X
DUE TO (b): Rheumatic Valvular heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c): Acute Coronary occlusion

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. none

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year: none 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) — (County) — (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10-18-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/21/1957
22c. NAME OF CEMETERY OR CREMATORY: Green Hill Cemetery
22d. LOCATION (City, town, or county): Waynesboro (State): Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: S. Martin Doe
ADDRESS: Waynesboro, Penna.
24a. REC'D BY REGISTRAR DATE: OCT 21 1957
24b. REGISTRAR'S SIGNATURE: Chas H Powers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11177

11199

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 32 Summit Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown
d. STREET ADDRESS 132 Summit Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Maurice Middle F. Last Hickey
4. DATE OF DEATH Month Oct. Day 30, Year 19 57
5. SEX male
6. COLOR OR RACE white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Jan. 29, 1876
9. AGE (In years last birthday) 81 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) street dept.
10b. KIND OF BUSINESS OR INDUSTRY city of Hag.
11. BIRTHPLACE (State or foreign country) Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Peter Hickey
14. MOTHER'S MAIDEN NAME Johana Cuffe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 217-09-9916A
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 331X Vascular Hypertension
DUE TO (b) Acute Cerebral hemorrhage
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. none
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year none 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none
20f. (City or town) - (County) - (State) -

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE S. Robert Wells M.D.
EXAMINER'S NAME (Type) S. Robert Wells, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 11-1-57

22a. BURIAL, CREMATION, REMOVAL (Specify) burial
22b. DATE THEREOF 11-4-57
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State) Hagerstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Scott F. Minnich & Son, Hagerstown, Md.
24a. REC'D BY REGISTRAR Nov. 1 1957
24b. REGISTRAR'S SIGNATURE Ethel H. Bowers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11178

11200

Reg. Dist. No. 302

1

M

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown — c. LENGTH OF STAY IN 1b: 9½ Hrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. County Hospital	d. STREET ADDRESS: 217 No Cannon Ave — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: JOHN	Middle: RAYMOND	Last: HUMMELSINE	4. DATE OF DEATH: Month Oct Day 14 Year 1957
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Jany 14 1890	9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant	10b. KIND OF BUSINESS OR INDUSTRY: Grocery	11. BIRTHPLACE (State or foreign country): Hagerstown Wash. Co Md.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: John Andrew Hummelsine	14. MOTHER'S MAIDEN NAME: Lillie Florence----------			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ------	16. SOCIAL SECURITY NO.: 214-09-8620	17. INFORMANT Address: Mrs Lola C. Hummelsine 217 No Cannon Ave		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — Hagerstown Md.

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Left ventricular Heart Failure	2 Wks
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Arteriosclerotic Heart Disease	4 yrs
DUE TO (c)		

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ---- 19 49 to Oct - 14 19 57, that I last saw the deceased alive on Oct 13 19 57, and that death occurred at 1:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Hoyd A. Hoffman M.D. — ADDRESS (Street, city or town, state): 214 N. Potomac St. Hagerstown, Md. — DATE SIGNED: 10/14/57

PHYSICIAN'S NAME (Type): Hoyd A. Hoffman

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	10/17/57	Rose Hill Cemetery	Hagerstown Wash. Co Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR Date	24b. REGISTRAR'S SIGNATURE
Andrew K. Coffman Hagerstown Md.	Oct. 17. 1957	Chas. H. Bowers

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11201

11179 **CERTIFICATE OF DEATH**

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: D. O. A.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Rural Hagerstown
d. STREET ADDRESS: 1 R.F.D. # 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

99

3. NAME OF DECEASED (Type or print): First CLYDE — Middle HERBERT — Last INGRAM

4. DATE OF DEATH: Month October — Day 8 — Year 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: October 18, 1894

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months 11 — Days 20 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Machinest Sup.

10b. KIND OF BUSINESS OR INDUSTRY: Manufacturing plant

11. BIRTHPLACE (State or foreign country): Shippensburg, Pennsylvania U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William M. Ingram

14. MOTHER'S MAIDEN NAME: Anna Hendrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-0326

17. INFORMANT: Mrs. Doris Stone — Address: Hagerstown Rt. # 3, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: minutes
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Heart Disease — 5 yrs
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1957 to Oct. 8 1957, that I last saw the deceased alive on Aug 10 1957, and that death occurred at 7 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clyde Hoffman M.D. — ADDRESS (Street, city or town, state): 214 N. Potomac St Hagerstown, Md. — DATE SIGNED: 10/9/57

PHYSICIAN'S NAME (Type): Lloyd A. Hoffman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/10/1957

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home R. Franklin Rouzer — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: 10/12/1957

24b. REGISTRAR'S SIGNATURE: Chas H Rowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely [illegible] in by the funeral director, [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG222 11-4-57 et

11202

11215

CERTIFICATE OF DEATH

Reg. Dist. No. 353

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown Md RFD
c. LENGTH OF STAY IN 1b: 6 month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Gateway Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Sharpsburg Maryland
d. STREET ADDRESS: 134 East Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS — Middle JEFFERSON — Last JACKSON

4. DATE OF DEATH: Month Oct. — Day 19 — Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Feb. 28 1881

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months 7 — Days 20 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Victor Products

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Alburtus Jackson

14. MOTHER'S MAIDEN NAME: Emma Myers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-10-3634

17. INFORMANT: Miss. Margaret Jackson — Address: 134 E. Main St. Sharpsburg Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Hypertrophy 7 days,
DUE TO
481X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Influenza
~~DUE TO~~
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 21 19 57 to Oct 19 19 57 that I last saw the deceased alive on Oct 19 19 57, and that death occurred at 7.30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: David R Brewer M.D. — ADDRESS (Street, city or town, state): Clear Spring — DATE SIGNED: 10/21/57

PHYSICIAN'S NAME (Type): David R. Brewer Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 22-57

22c. NAME OF CEMETERY OR CREMATORY: Samples Manor Cemetery

22d. LOCATION (City, town, or county) (State): Samples Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Albert L Leaf — ADDRESS: Williamsport, Md.

24a. REC'D BY REGISTRAR DATE: Oct 23 57

24b. REGISTRAR'S SIGNATURE: Leroy M Zechler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11180

CERTIFICATE OF DEATH

Reg. Dist. No. 11203 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 50 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 544 Guilford Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Frances — Middle Jeanette — Last Jones

4. DATE OF DEATH: Month October — Day 5 — Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 22, 1907

9. AGE (In years last birthday): 50 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Hagerstown Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry Kountz

14. MOTHER'S MAIDEN NAME: Eva M. Stouffer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: ----

17. INFORMANT — Address: Leroy Jones Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of thyroid with
DUE TO
(b): Metastasis
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

194X

INTERVAL BETWEEN ONSET AND DEATH: 4 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec, 1952, to Oct 5, 1957, that I last saw the deceased alive on Oct 5, 1957, and that death occurred at 6:47 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Campbell M.D. — ADDRESS (Street, city or town, state): 145 W. Washington St. Hagerstown — DATE SIGNED

PHYSICIAN'S NAME (Type): Dr. Robert Campbell md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-8-57
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son Hagerstown Md.

24a. RECD BY REGISTRAR — DATE: Oct. 9, 1957

24b. REGISTRAR'S SIGNATURE: Chas. H. Powers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11181 — 11204

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 19 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1045 Florida Ave.

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 1045 Florida Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle A. — Last KEESECKER

4. DATE OF DEATH: Month Oct. — Day 5 to7 — Year 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 12, 1883

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Janitor

10b. KIND OF BUSINESS OR INDUSTRY: Laundry

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-8378

17. INFORMANT: Mrs. Marie Baughman — Address: Pheonix, Arizona

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 420.1
DUE TO (b): Coronary Thrombosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10/9/57

EXAMINER'S NAME (Type): DR E W [illegible] JR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/11/1957
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — R. Franklin Rouzer
ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: Oct 12 1957
24b. REGISTRAR'S SIGNATURE: Martha Bowers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for [illegible] files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11205

: 11182

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 352 Linganore Ave.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 352 Linganore Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elmer — Middle: Benjamin — Last: Kershner

4. DATE OF DEATH: Month: 10 — Day: 27 — Year: 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 5, 1868

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired laborer

10b. KIND OF BUSINESS OR INDUSTRY: N.Y. Central Iron Wks

11. BIRTHPLACE (State or foreign country): Wash. Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lanlear Kershner

14. MOTHER'S MAIDEN NAME: Mary Ellen Ringer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Ira Kershner — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infuction — INTERVAL BETWEEN ONSET AND DEATH: 1 Da.
420.0
DUE TO (b): Arteriosclerotic Heart Disease — 10 Yrs
DUE TO (c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/15/57, 19____, to 10/27/57, 19____, that I last saw the deceased alive on 10/25/57, 19____, and that death occurred at 6:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl Young M.D. — ADDRESS (Street, city or town, state): Hagerstown Md — DATE SIGNED: 10/29/57

PHYSICIAN'S NAME (Type): SEARL YOUNG MD — HAGERSTOWN, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 10-29-57

22c. NAME OF CEMETERY OR CREMATORY: Broadfording

22d. LOCATION (City, town, or county) (State): Broadfording Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Fred W. Kraiss Hagerstown, Md.

24a. REC'D BY REGISTRAR: Oct. 31. 1957

24b. REGISTRAR'S SIGNATURE: Chas. H. Brewer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely [illegible] in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be attached with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11216

CERTIFICATE OF DEATH

11206

Reg. Dist. No. 305

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boonsboro
c. LENGTH OF STAY IN 1b: 8 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Reeder Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smithsburg
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Milva Middle Mae Last Kinsey

4. DATE OF DEATH: Month October Day 23 Year 19 57

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 13, 1873

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Boonsboro, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Dallas Ford

14. MOTHER'S MAIDEN NAME: Prudence Hutzell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT Address: Robert L. Kinsey, Smithsburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 8 yrs
DUE TO
(b): 443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 22, 57 19 57, to Oct 23, 19 57, that I last saw the deceased alive on Oct 23, 19 57, and that death occurred at 10:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert P. Conrad M.D. — ADDRESS (Street, city or town, state): 137 W. Washington — DATE SIGNED: 10-25-57

PHYSICIAN'S NAME (Type): Robert P. Conrad — Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 10-26-57
22c. NAME OF CEMETERY OR CREMATORY: Boonsboro Cemetery
22d. LOCATION (City, town, or county) (State): Boonsboro, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Smithsburg, Md.

24a. REC'D BY REGISTRAR DATE: Oct. 26 1957

24b. REGISTRAR'S SIGNATURE: John D. Bast

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11217

CERTIFICATE OF DEATH

Reg. Dist. No. 11207 335

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Boonsboro
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X1 Rural Smithburg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Calvin; Middle:; Last: Kline

4. DATE OF DEATH: Month: 10; Day: 27; Year: 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/27/1880

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farm owner

10b. KIND OF BUSINESS OR INDUSTRY: farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Michael Kline

14. MOTHER'S MAIDEN NAME: Mary Catherine Maugans

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT Address: Mrs. Juanita Weiss, Smithburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.
DUE TO
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 21, 1957, to Oct 27, 1957, that I last saw the deceased alive on October 25, 1957, and that death occurred at 11 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G. W. LeVan M.D.
ADDRESS (Street, city or town, state): Boonsboro —
DATE SIGNED: 10/28/57

PHYSICIAN'S NAME (Type): Dr. Gerald Levan — Boonsboro, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 10/30/1957
22c. NAME OF CEMETERY OR CREMATORY: U.B. Cemetery
22d. LOCATION (City, town, or county) (State): Wolfsville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Gladhill Co , Middletown, Md.

24a. REC'D BY REGISTRAR DATE: 10-31-57
24b. REGISTRAR'S SIGNATURE: Mrs. Katherine Doguhart

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11183 — 11208 — Reg. Dist. No. 3021

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 hr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Alexander Hotel Tap Room

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: West Virginia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Martinsburg — 85 X-3
d. STREET ADDRESS: R # 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Leroy — Last: Lightner
4. DATE OF DEATH: Month: Oct. — Day: 18 — Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 6, 1879
9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): President
10b. KIND OF BUSINESS OR INDUSTRY: Rose Dale Cemetery
11. BIRTHPLACE (State or foreign country): Union Bridge, Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William Lightner
14. MOTHER'S MAIDEN NAME: Emma Jane Hiltabidle
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: 234-01-8555
17. INFORMANT — Address: Mrs. Jack E. Sherrad- R#3 Martinsburg, W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Coronary Occlusion	
420.1 DUE TO	Generalized Arteriosclerosis	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)		
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. None
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None
20c. TIME OF INJURY — Hour o. m. p. m. — Month, Day, Year: None 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): None
20f. (City or town) - (County) - (State) -

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: Oct. 18 '57
EXAMINER'S NAME (Type): S. Robert Wells, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-22-57
22c. NAME OF CEMETERY OR CREMATORY: Rose Dale Cemetery
22d. LOCATION (City, town, or county) (State): R# 3 Martinsburg, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE: Kogelschatz & Coffman — ADDRESS: Martinsburg, W. Va.
24a. REC'D BY REGISTRAR — DATE: Oct. 24 1957
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11218 — Reg. Dist. No. 11209 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Security Md.
c. LENGTH OF STAY IN 1b: Minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Security Md

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xo Hagerstown Md. RFD 6
d. STREET ADDRESS: Hagerstown, Md RFD 6
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Phyllis — Middle: Marie — Last: Malloy
4. DATE OF DEATH: Month: Oct. — Day: 20 — Year: 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 22 1930
9. AGE (In years last birthday): 27 yrs.
IF UNDER 1 YEAR: Months: 8 Days: 27
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dress Maker
10b. KIND OF BUSINESS OR INDUSTRY: L& Ailon Co.
11. BIRTHPLACE (State or foreign country): Clearspring Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Carl Miles
14. MOTHER'S MAIDEN NAME: Edna Eshelman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 218-24-9267
17. INFORMANT: Mr. Robert Malloy — Address: Hagerstown, Md RFD 6

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Open Fracture skull — INTERVAL BETWEEN ONSET AND DEATH: 10 Min.
DUE TO (b): Multiple fracture ribs
DUE TO (c): ~~Closed fracture lt. femur~~
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto- train collison
20c. TIME OF INJURY Hour: 5:20 p. m. Month, Day, Year: Oct. 20, 57
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): R.R. Track-Security
20f. (City or town) (County) (State): Rural- Hagerstown Md

21. I certify that I took charge of the remoins described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Noturol cause ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D.
EXAMINER'S NAME (Type): S. Robert Wells, M.D.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Oct. 21 '57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 24-57
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Edith V. Leaf — ADDRESS: Williamsport
24a. REC'D BY REGISTRAR DATE: Oct. 23. 1957
24b. REGISTRAR'S SIGNATURE: Thos. H. Bowers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. SR Wells 11184 **CERTIFICATE OF DEATH**

11210

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1111 Salem Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 1111 Salem Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle EMERSON Last MARTIN

4. DATE OF DEATH: Month October Day 26, Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 3,1883

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conductor-Penna.R.R.-Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Chambersburg,Franklin Co.,Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Abraham Martin

14. MOTHER'S MAIDEN NAME: Mary C. Ebersole

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - - - - - -

16. SOCIAL SECURITY NO.: 716-09-9418

17. INFORMANT Address: Mrs. Nan C. Martin-1111 Salem Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma lymph gland of neck — INTERVAL BETWEEN ONSET AND DEATH: 8 mos
DUE TO (b): Arteriosclerotic myocardial heart disease
DUE TO (c):

198x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year: None 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): None

20f. (City or town) - (County) - (State) - -

21. I certify that I attended the deceased from Dec. 1951, to Oct. 26, 1957, that I last saw the deceased alive on Oct. 22, 1957, and that death occurred at 7:05 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Robert Wells M.D.

ADDRESS (Street, city or town, state): 115 N. Potomac Street, Hagerstown, Maryland

DATE SIGNED: 10-26-57

PHYSICIAN'S NAME (Type): S. Robert Wells, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-28-57

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman-Hagerstown, Maryland

24a. REC'D BY REGISTRAR: Oct. 30. 1957

24b. REGISTRAR'S SIGNATURE: Ethel H Rosevelt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11211

11185

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Maugansville
d. STREET ADDRESS: 1 Maugansville, Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MENNO — Middle: S. — Last: MARTIN

4. DATE OF DEATH: Month: Oct — Day: 26 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/3/1894

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Milnor, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel W. Martin

14. MOTHER'S MAIDEN NAME: Rebecca Shank

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unk'n): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-26-7348

17. INFORMANT — Address: Mrs. Mary Martin - Maugansville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
420.0
DUE TO
(b): Arteriosclerotic Heart Dis — 2 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-1-, 1957, to 10-26, 1957, that I last saw the deceased alive on 10-25-, 1957, and that death occurred at 11:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. D. Ortt Jr. M.D. — ADDRESS (Street, city or town, state): Hagerstown Md — DATE SIGNED: 10/26/57

PHYSICIAN'S NAME (Type): Dr. E.W. Ortt Jr. — Hagerstown Md — 10/26/57

22a. BURIAL, CREMATION, REMOVAL (Specify): B

22b. DATE THEREOF: 10/29/57

22c. NAME OF CEMETERY OR CREMATORY: Reiff Cem.

22d. LOCATION (City, town, or county) (State): Clearspos, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: A.E. Minnich — ADDRESS: Greencastle Pa.

24a. RECD BY REGISTRAR DATE: 10.29.1957

24b. REGISTRAR'S SIGNATURE: Chas. H. Loewer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11186

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11212

Reg. Dist. No. 382

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 317 S. Potomac St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William; Middle: Mearl; Last: Martin

4. DATE OF DEATH: Month: 10; Day: 25; Year: 19 57

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 3-25-1889

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired guard

10b. KIND OF BUSINESS OR INDUSTRY: Fairchilds

11. BIRTHPLACE (State or foreign country): Wash. Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Martin

14. MOTHER'S MAIDEN NAME: Mary Alexander

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 220-09-9316

17. INFORMANT: Charles W. Martin — Address: Hughson, Calif.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH:
420.1
DUE TO (b): Generalized vascular arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year: None 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) — (County) — (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Robert Wells M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10-28-57

EXAMINER'S NAME (Type): S. Robert Wells, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 10-30-57

22c. NAME OF CEMETERY OR CREMATORY: Brownsville

22d. LOCATION (City, town, or county) (State): Brownsville Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Fred W. Kraiss Hagerstown, Md.

24a. REC'D BY REGISTRAR: Oct. 31. 1957

24b. REGISTRAR'S SIGNATURE: Elizabeth Access

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11187

CERTIFICATE OF DEATH

11213

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 3 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 143 WEST FRANKLIN ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 809 FLORIDA AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

DR. PAUL HARRISON 318 N. POTOMAC ST. HAGERSTOWN MD

3. NAME OF DECEASED (Type or print): First: FLORENCE Middle: ELIZABETH Last: MORGAN

4. DATE OF DEATH: Month: OCTOBER Day: 2 Year: 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MARCH 10 1873

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): BOONSBORO WASH.CO.MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN FURRY

14. MOTHER'S MAIDEN NAME: MARY WISSINGER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: ALVEY C.MORGAN 809 FLORIDA AVENUE HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 6 yrs

420.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1955, to Oct 2, 1957, that I last saw the deceased alive on Oct 1, 1957, and that death occurred at 4 30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul Harrison M.D. ADDRESS (Street, city or town, state): 318 N. Potomac ST DATE SIGNED: 10-4-57

PHYSICIAN'S NAME (Type): PAUL HARRISON Hagerstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: OCT.5 1957

22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY

22d. LOCATION (City, town, or county) (State): BOONSBORO WASH.CO.MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Bast Funeral Home ADDRESS: Boonsboro md

24a. REC'D BY REGISTRAR DATE: Oct. 7 1957

24b. REGISTRAR'S SIGNATURE: Grant Bowers

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11188

CERTIFICATE OF DEATH

11214

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 rural Smithsburg
d. STREET ADDRESS: 1 RFD 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Daniel; Middle: Elmer; Last: Muritz

4. DATE OF DEATH: Month: Oct. Day: 16, Year: 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 12, 1884

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): freight handler

10b. KIND OF BUSINESS OR INDUSTRY: railroad

11. BIRTHPLACE (State or foreign country): Middleburg, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Muritz

14. MOTHER'S MAIDEN NAME: Anna Swisher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-10-5192

17. INFORMANT: Address: Mrs. Effie Muritz, Smithsburg, Rd2 M

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 11 days
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic heart disease — 1½ years
DUE TO
(c) Hypertensive cardiovascular disease — 7½ years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 5, 1957, to Oct. 16, 1957 that I last saw the deceased alive on Oct. 16, 1957, and that death occurred at 10:55 A.M., D.S.T., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. D. Layman, MD — M.D. — ADDRESS (Street, city or town, state): 100 Professional Arts Bldg., Hagerstown, Maryland — DATE SIGNED: 10/17/57

PHYSICIAN'S NAME (Type): William T. Layman, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 10-19-57

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: Oct 19 1957

24b. REGISTRAR'S SIGNATURE: Chas H Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11189 **CERTIFICATE OF DEATH** 11215

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY: Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown x 2
d. STREET ADDRESS: Route #5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle EDGAR Last MYERLY
4. DATE OF DEATH: Month 10 Day 12 Year 19 57

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec.1,1892
9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shovel Operator
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Carroll County,Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Mary E.McKenney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-05-8676
17. INFORMANT: Mrs.Maud L.Myerly Address: R# 5 Hagerstown,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Carcinoma, metastatic	6 mos
DUE TO (b)	Carcinoma Bronchiogenic	6 mos
DUE TO (c)		

162X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug, 1957, to Oct 12, 1957, that I last saw the deceased alive on Oct 11, 1957, and that death occurred at 7 20 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert V.L. Campbell M.D.
ADDRESS (Street, city or town, state): 145 W Washington ST Hagerstown Md.
DATE SIGNED: 10/14/57
PHYSICIAN'S NAME (Type): Robert V.L. Campbell

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/15/57
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county): Hagerstown (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel Inc. ADDRESS: 1601 Penna.Ave. Hagerstown,Md.
24a. REC'D BY REGISTRAR DATE: Oct.14 1957
24b. REGISTRAR'S SIGNATURE: Chas H. Bowers

Wm. G. Horst V-Pres.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11219

CERTIFICATE OF DEATH

11216 207

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Garrotts Mills
c. LENGTH OF STAY IN 1b: 8888
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Garrotts Mills
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Victoria — Middle: Almeda — Last: Myers

4. DATE OF DEATH: Month: 10 — Day: 8 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10-7-1873

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Richard H. Lutrell

14. MOTHER'S MAIDEN NAME: Eliza Jane Lutrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-34-0731

17. INFORMANT — Address: Roy Logue, Brunswick, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia, Anemia, Arterial Sclerosis
DUE TO
451X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized Arterial Sclerosis
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: 2 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-7-, 1957, to 10-8-, 1957, that I last saw the deceased alive on 10-8, 1957, and that death occurred at 6:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): Brunswick, Md.

DATE SIGNED: 10-9-57

PHYSICIAN'S NAME (Type): C. E. PRUITT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-11-57

22c. NAME OF CEMETERY OR CREMATORY: Park Heights

22d. LOCATION (City, town, or county) (State): Brunswick, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [signature]

ADDRESS: Brunswick, Maryland

24a. REC'D BY REGISTRAR — DATE: OCT 14 1957

24b. REGISTRAR'S SIGNATURE: Katherine Degenhardt

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11220

CERTIFICATE OF DEATH

11217

Reg. Dist. No. 302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Gateway Nursing home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Md.
d. STREET ADDRESS: 102 Rowe St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle — Last OVAC

4. DATE OF DEATH: Month October — Day 9 — Year 19 57

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 6, 1875

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months 7 — Days 3
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Tube miller

10b. KIND OF BUSINESS OR INDUSTRY: Cement company

11. BIRTHPLACE (State or foreign country): Hungary

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 213-10-6908

17. INFORMANT — Address: Mrs. John Filipovitz Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

422.1

DUE TO (b): Arteriosclerotic C V disease — Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491x

DUE TO (c): Atherosclerosis — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Prostatic hypertrophy

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 10, 19 57, to Oct 9, 19 57, that I last saw the deceased alive on Oct 9, 19 57, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. L Packer Jr M.D. — ADDRESS (Street, city or town, state): 145 W. Washington — DATE SIGNED: 10/10/57

PHYSICIAN'S NAME (Type): L. L. PACKER JR, Hagerstown, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/11/1957

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — R. Franklin Rouzer

ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: Oct-14-57

24b. REGISTRAR'S SIGNATURE: Leroy M Fahlen (Deputy)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11221

11218

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and signed by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairplay R # 1
c. LENGTH OF STAY IN 1b: 7 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Fairplay R # 1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Fairplay R # 1
d. STREET ADDRESS: 1 Fairplay R # I
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANDREW Middle JACKSON Last PAINTER

4. DATE OF DEATH: Month 10 Day 20 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12/27/1862

9. AGE (In years last birthday): 94 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ca binet Maker

10b. KIND OF BUSINESS OR INDUSTRY: Furniture

11. BIRTHPLACE (State or foreign country): Loudoun Co.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joushia Painter

14. MOTHER'S MAIDEN NAME: Louise Clipp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr.Harold Near Address: Fairplay, Md. Route # I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia, Lobar — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO
490 x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug, 1957 to 20 Oct, 1957, that I last saw the deceased alive on 20 Oct, 1957, and that death occurred at 3:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul Haak M.D. — ADDRESS (Street, city or town, state): 28 West Potomac St. Williamsport, Md. — DATE SIGNED: 21 Oct 57

PHYSICIAN'S NAME (Type): Pa ul Haak M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/23/57

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel Inc. ADDRESS: 1601 Penna. Ave. Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: Oct. 24. 1957

24b. REGISTRAR'S SIGNATURE: John H. Bast

Wm. A. Hart & Bro

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11190

CERTIFICATE OF DEATH

Dr. Wilson 11-1502

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 819 Mulberry Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Glenn — Middle: Leroy — Last: Piper

4. DATE OF DEATH: Month: Oct — Day: 23 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 3, 1884

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inspector-Pangborn-Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Saxton-Bedford Co. Penn.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William L. Piper

14. MOTHER'S MAIDEN NAME: Martha Ann Sheets

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - - - -

16. SOCIAL SECURITY NO.: 214-09-6133

17. INFORMANT: Mr Paul L Piper — Address: Pittsburgh.Penna.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Toxicity from Gangrene Rt Leg. — INTERVAL BETWEEN ONSET AND DEATH: 5 days
420.1
DUE TO
(b): Arteriosclerosis — Years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Coronary Thrombosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 1, 19 57, to 23 Oct, 19 57, that I last saw the deceased alive on 23 Oct, 19 57, and that death occurred at 5:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J D Wilson, M.D. — ADDRESS (Street, city or town, state): Hagerstown, Md. — DATE SIGNED: 10/26/57

PHYSICIAN'S NAME (Type): J. D WILSON M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct 26, 1957

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown, Mdm

24a. REC'D BY REGISTRAR: Oct. 28 1957

24b. REGISTRAR'S SIGNATURE: Elizabeth Boewsk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11191

CERTIFICATE OF DEATH

11220

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ×2. Rural Hagerstown
d. STREET ADDRESS: R.F.D. # 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KARLA — Middle MARIA — Last QUINN

4. DATE OF DEATH: Month October — Day 11 — Year 1957

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 9, 1957

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months — Days 2 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James J. Quinn

14. MOTHER'S MAIDEN NAME: Jeanne E. Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mr. James J. Quinn — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
762.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10.9.57, 19____, to 10.11.57, 19____, that I last saw the deceased alive on 10.11.57, 19____, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl Young M.D. — ADDRESS (Street, city or town, state): Hagerstown, Md — DATE SIGNED: 10.11.57

PHYSICIAN'S NAME (Type): EARL YOUNG MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/12/1957

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — R. Franklin Rouzer — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: Oct. 12. 1957

24b. REGISTRAR'S SIGNATURE: Elmer H. Boerner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2281337XV4

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG222 11-14-57 et

11222

11221

CERTIFICATE OF DEATH

Reg. Dist. No. 308

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hancock 2
c. LENGTH OF STAY IN 1b: 1Yr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XO Rural 2 Hancock Maryland.
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ricky; Middle: Glenn; Last: Ray

4. DATE OF DEATH: Month: 10. Day: 25 Year: 19 57

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 11-11-55 10/11/1955

9. AGE (In years last birthday): 1 yrs.

IF UNDER 1 YEAR: Months: 11 Days: 13
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Berkeley Sounty W.VA.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Glenn A Ray

14. MOTHER'S MAIDEN NAME: Lucille R Barnes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Glenn A Ray Rural 2 Hancock Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Virus Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7da
492 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 25, 19 57, to Oct 25, 19 57, that I last saw the deceased alive on Oct 25, 19 57, and that death occurred at M, from the causes and an the date stated above.

ACTUAL SIGNATURE: L M Shoffer M.D.
ADDRESS (Street, city or town, state): Hancock Md
DATE SIGNED: 10/27/57
PHYSICIAN'S NAME (Type): L. M. SHAFFER M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10.28.57

22c. NAME OF CEMETERY OR CREMATORY: Orchard Ridge Cemetery

22d. LOCATION (City, town, or county) (State): Near Hancock Washington MD

23. FUNERAL DIRECTOR'S SIGNATURE: Howard F Stone
ADDRESS: Hancock md

24a. REC'D BY REGISTRAR DATE: 10/28/57

24b. REGISTRAR'S SIGNATURE: J C Nidel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11223

CERTIFICATE OF DEATH

11222

Reg. Dist. No. 305

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): APPLETOWN RURAL
c. LENGTH OF STAY IN 1b: 7 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: BOONSBORO MD. ROUTE 2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X0 APPLETOWN RURAL
d. STREET ADDRESS: BOONSBORO MD. ROUTE 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CLARENCE — Middle E. — Last RICE

4. DATE OF DEATH: Month OCT. — Day 9 — Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 9 1911

9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TRUCK DRIVER WASH. CO. ROAD DEPT.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): LOCUST GROVE WASH. CO. MD. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: SAMUEL C. RICE

14. MOTHER'S MAIDEN NAME: META M. CROWL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-10-3071

17. INFORMANT — Address: MRS. GRACE RICE BOONSBORO MD. ROUTE 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
420.1
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 9, 1957, to Oct 9, 1957, that I last saw the deceased alive on October 9, 1957, and that death occurred at 8 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G. W. Litsey M.D.
ADDRESS (Street, city or town, state): Boonsboro
DATE SIGNED: 10/11/57

PHYSICIAN'S NAME (Type): G. W. LeVan md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: OCT. 12 1957
22c. NAME OF CEMETERY OR CREMATORY: LOCUST GROVE CEMETRY
22d. LOCATION (City, town, or county) (State): LOCUST GROVE WASH. CO. MD

23. FUNERAL DIRECTOR'S SIGNATURE: East End Home — ADDRESS: Boonsboro Md
24a. REC'D BY REGISTRAR DATE: Oct 12 1957
24b. REGISTRAR'S SIGNATURE: John A. Bath

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11192

11223

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 28 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 621 Guilford Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 621 Guilford Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RUTH Middle MARGUERITE Last RICKRODE

4. DATE OF DEATH: Month October Day 10 Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 11, 1895
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months 8 Days 29
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Chambersburg, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Adam Crist
14. MOTHER'S MAIDEN NAME: Mary Wise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mr. Louis Rickrode — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Occlusion	suddenly
DUE TO (b)	Hypertensive Cardiovascular Renal	8 yrs.
DUE TO (c)	Cerebral Hemorrhage	8 yrs.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 19 57 to Oct 10 19 57, that I last saw the deceased alive on Oct 24 1957, and that death occurred at 4 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip J. Kolman M.D. — ADDRESS (Street, city or town, state): 1590 Washington St Hagerstown Md — DATE SIGNED: 10/11/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/12/1957
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home — R. Franklin Rouzer — ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE: Oct. 12 1957
24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11224

11193 **CERTIFICATE OF DEATH**

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 15 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 51 West Franklin St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 51 West Franklin St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BETTIE — Middle --- — Last RUBEN

4. DATE OF DEATH: Month Oct — Day 9 — Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 2 1893
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Hagerstown Wash. Co Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Max Ruben
14. MOTHER'S MAIDEN NAME: Lena Simon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -----
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Aaron S. Ruben — Address: 1133 Hamilton Blvd Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary occlusion	Suddenly
DUE TO (b)	Hypertensive Cardiovascular Disease	4 yrs.
DUE TO (c)	Suspected Carcinoma of ovary.	2 mo.

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 23, 1935, to Oct 9, 1957, that I last saw the deceased alive on Oct 9 1957, and that death occurred at 5 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip J. Hirshman M.D.
ADDRESS (Street, city or town, state): 150 W. Washington St. Hagerstown Md
DATE SIGNED: 10/10/57
PHYSICIAN'S NAME (Type): PHILIP J. HIRSHMAN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 11-1957
22c. NAME OF CEMETERY OR CREMATORY: B'Nai Abraham Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Wash. Co Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.
24a. REC'D BY REGISTRAR: Oct. 11 1957
24b. REGISTRAR'S SIGNATURE: Chas. A. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11194

CERTIFICATE OF DEATH

Reg. Dist. No. 11225 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Md.
c. LENGTH OF STAY IN 1b: 60yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 136 William Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown Maryland
d. STREET ADDRESS: 136 William Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Curtis — Middle: Henry — Last: Scott

4. DATE OF DEATH: Month: 10 — Day: 28 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb 25 1878

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY: Private family

11. BIRTHPLACE (State or foreign country): Hagerstown Maryland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: George Scott

14. MOTHER'S MAIDEN NAME: Mary Waters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Jane Scott — Address: 136 William Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immed.
420.0
DUE TO (b): Arteriosclerotic heart disease — 15 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): + hypertensive vascular disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Possible pneumoconiosis — or pulmonary cyst

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 1, 1955, to Oct. 28, 1957, that I last saw the deceased alive on Oct 22, 1957, and that death occurred at 9:00 p. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward W. Ditto III M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED: 10/30/57

PHYSICIAN'S NAME (Type): Edward W. Ditto III, M.D. 217 W. Washington St. Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-25-1957

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John R Watson Jr — ADDRESS: Hagerstown Md.

24a. REC'D BY REGISTRAR: Nov. 1. 1957

24b. REGISTRAR'S SIGNATURE: Thad H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11195 **CERTIFICATE OF DEATH** Reg. Dist. No. 11226

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 404 Linganore Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
HERMAN	DAVID	SHANK	10	16	19 57

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		June 13,1906	51 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Milk receiving station	Dairy	Hagerstown,Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Willia m S.Shank	Nettie C.Carbaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	214-09-0049	Mrs.Herman Shank 404 Linganore Ave. Hagerstown Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Myocardial Infarction.	1/2 hour
DUE TO (b)	Coronary Atherosclerosis	Unknown.
DUE TO (c)		

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8.1.34, 19____, to 10.16.57, 19____, that I last saw the deceased alive on 10.15.57, 19____, and that death occurred at 8.30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl Young M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type): S.Earl Young M.D. — 148 N.Potomac St. Hagerstown,Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	10/18/57	Broadfording Cemetery	Broadfording,Washington Co.Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Rest Haven Funeral Chapel Inc. 1601 Penna. Ave. Hagerstown,Md.	Oct.18.1957	Chas.H.Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11224 11227

Reg. Dist. No. 305

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Boonsboro
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): -

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X/ Rural Monree- R # 1 Boonsboro
d. STREET ADDRESS: / R # 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Ralph Otho James — Middle — Last: Shifler

4. DATE OF DEATH: Month: Oct. — Day: 12 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: Dec. 7, 1893

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Self employed

11. BIRTHPLACE (State or foreign country): Boonsboro, Md R # 1

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Otho Shifler

14. MOTHER'S MAIDEN NAME: Arbelia Doub

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): # 1

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mr. Ralph E. Shifler - Halfway, Hagerstown, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Suffocation by hanging
974x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Hanged self in corn crib at home

20c. TIME OF INJURY — Hour: 6 xxxx p. m. — Month, Day, Year: Oct. 12 1957

20d. INJURY OCCURRED While at work [ ] Not while at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm

20f. (City or town) (County) (State): Rural Boonsboro, Wash. Md

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [✓], Inquiry [ ], and find that death resulted from: Natural causes [ ], Accident [ ], Suicide [✓], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: S. Robert Wells M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [✓]
DATE SIGNED: 10-14-57

EXAMINER'S NAME (Type): S. Robert Wells, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-15-57
22c. NAME OF CEMETERY OR CREMATORY: Boonsboro Cemetery
22d. LOCATION (City, town, or county) (State): Boonsboro, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Bast Funl Home Boonsboro Md.

24a. REC'D BY REGISTRAR — DATE: Oct. 15 1957
24b. REGISTRAR'S SIGNATURE: John H. Bast

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

VS. A1SME(S)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11225

CERTIFICATE OF DEATH

11228

Reg. Dist. No. 303

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clearspring R 1
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X/ Clearspring
d. STREET ADDRESS: Route 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Martha — Middle: Cline — Last: Shupp

4. DATE OF DEATH: Month: 10 — Day: 25 — Year: 19 57

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Dec. 21, 1876

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Wash. Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lewis Hose

14. MOTHER'S MAIDEN NAME: Lydia Vandrew

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Edward Shupp — Address: Clearspring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 332x
DUE TO (b): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 mo
DUE TO (c): Senile arteriosclerosis — 10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-1-, 1956, to 10-25, 1957, that I last saw the deceased alive on 10-29-57, 19____, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr. E W Dietz — M.D. — ADDRESS (Street, city or town, state): Hagerstown Md — DATE SIGNED: 10/30/57

PHYSICIAN'S NAME (Type): Dr. E W Dietz — Hagerstown Md — 10/30/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-28-57

22c. NAME OF CEMETERY OR CREMATORY: St. Pauls

22d. LOCATION (City, town, or county): Hagerstown Rural — (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Fred W. Kraiss — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: Oct 30-57

24b. REGISTRAR'S SIGNATURE: Jos. W. Murray

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11196

CERTIFICATE OF DEATH

11229

Reg. Dist. No. 303

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 735 Dale St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JEAN — Middle MAY — Last SISLER

4. DATE OF DEATH: Month 10 — Day 17 — Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/9/41

9. AGE (In years last birthday): 16 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: High School

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frances E. Sisler Sr.

14. MOTHER'S MAIDEN NAME: Mildred May Wolfe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mr. Frances E. Sisler R #1 Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Status Asthmaticus & Grand Mal — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
241X
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/16/57, 19____, to 10/17/57, 19____, that I last saw the deceased alive on 10/17/57, 19____, and that death occurred at 7:02 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph F. Young M.D. — ADDRESS (Street, city or town, state): Williamsport, Md. — DATE SIGNED: 10/17/57

PHYSICIAN'S NAME (Type): Ralph F. Young M.D. — 101 E. Potomac St. Williamsport, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/20/57
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Rest Haven Funeral Chapel Inc. 1601 Penna. Ave. Hagerstown, Md.

24a. REC'D BY REGISTRAR — DATE: Oct. 19 1957

24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely [illegible] in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11226

CERTIFICATE OF DEATH

11230

Reg. Dist. No. 305

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BOONSBORO
c. LENGTH OF STAY IN 1b: 23 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HIGH STREET

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 BOONSBORO
d. STREET ADDRESS: HIGH STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle ELLEN — Last SMITH

4. DATE OF DEATH: Month OCTOBER — Day 18 — Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 2 1866

9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE KEEPER

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): NEAR BOONSBORO WASH.CO.MD. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ANDREW W.SMITH

14. MOTHER'S MAIDEN NAME: ELIZABETH PALMER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address: ROY SMITH HIGH ST.BOONSBORO MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

450.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 10, 1957 to Oct. 18, 1957, that I last saw the deceased alive on Oct. 17, 1957, and that death occurred at 3 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G.WileVan M.D.

ADDRESS (Street, city or town, state): Boonsboro Md.

DATE SIGNED: 10/19/57

PHYSICIAN'S NAME (Type): G.WileVan

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: OCT.20 1957

22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY

22d. LOCATION (City, town, or county) (State): BOONSBORO WASH.CO.MD.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Bast Funeral Home Boonsboro Md

24a. REC'D BY REGISTRAR DATE: Oct 20 1957

24b. REGISTRAR'S SIGNATURE: John H. Bast

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11227

CERTIFICATE OF DEATH

11231

Reg. Dist. No. 5303

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL CLEAR SPRING
c. LENGTH OF STAY IN 1b: 35 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 RURAL CLEAR SPRING RTI
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MAYETTE — Middle EMERSON — Last SMITH SR.

4. DATE OF DEATH: Month IO — Day I — Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH:

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONDUCTOR

10b. KIND OF BUSINESS OR INDUSTRY: W.M.R.R.

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT L. SMITH

14. MOTHER'S MAIDEN NAME: EDA RIDGE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WAR I

16. SOCIAL SECURITY NO.: 705-IO-4800

17. INFORMANT: MRS. VIOLA SMITH — Address: CLEAR SPRING RTI

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.
002X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 16, 1955 to Oct 1, 1957 that I last saw the deceased alive on Oct 1, 1957, and that death occurred at 4:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: David R Brewer M.D. — ADDRESS (Street, city or town, state): Clear Spring Md — DATE SIGNED: 10/2/57

PHYSICIAN'S NAME (Type): David R Brewer

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: OCT 4, 1957

22c. NAME OF CEMETERY OR CREMATORY: PARK HEAD CEMETERY

22d. LOCATION (City, town, or county) (State): WASHINGTON CO., MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John F. Clark — ADDRESS: Clear Spring, Md.

24a. REC'D BY REGISTRAR DATE: 10/7/57

24b. REGISTRAR'S SIGNATURE: Leroy M Fockler (Deputy)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11228

CERTIFICATE OF DEATH

11232

Reg. Dist. No. 300

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharpsburg
c. LENGTH OF STAY IN 1b: 86 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Sharpsburg Maryland

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 116 E. Main Street

d. STREET ADDRESS: 116 E. Main Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DAISY — Middle — Last SWAIN

4. DATE OF DEATH: Month Oct. — Day 20 — Year 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 13 1871

9. AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR: Months 7 — Days 6 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Sharpsburg Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Clinton Swain

14. MOTHER'S MAIDEN NAME: Elizabeth Highberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Charles Mc Graw — Address: 116 E. Main St. Sharpsburg Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broncho-pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

480 X

DUE TO
(b): Influenza — 2 weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertensive, arteriosclerotic cardio-vascular-renal disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 7 19 57 to October 20 19 57, that I last saw the deceased alive on Oct. 20, 1957 19 , and that death occurred at 3 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter H. Shealy M.D.

ADDRESS (Street, city or town, state): Sharpsburg, Md.

DATE SIGNED: 10/21/57

PHYSICIAN'S NAME (Type): Walter H. Shealy M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 23-57

22c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery

22d. LOCATION (City, town, or county) (State): Sharpsburg Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Albert Leaf — ADDRESS: Williamsport, Md

24a. REC'D BY REGISTRAR DATE: Oct 23-57

24b. REGISTRAR'S SIGNATURE: E. J. Boyer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG222 10-29-57 et

11197

CERTIFICATE OF DEATH

11233

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown Maryland 03
d. STREET ADDRESS: 341 N. Jonathan Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Allison — Last: Tate
4. DATE OF DEATH: Month: Oct — Day: 17 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ■ DIVORCED ☐
8. DATE OF BIRTH: March 18 1883
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: Private family
11. BIRTHPLACE (State or foreign country): Statesville, N.C.
12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Abner Allison
14. MOTHER'S MAIDEN NAME: Raely Allison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: James Tate — Address: Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Volvulus of Colon — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Nephrosclerosis
DUE TO
(c):
570.3
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 27, 1957, to Oct 17, 1957, that I last saw the deceased alive on Oct 16, 1957, and that death occurred at 1 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip J. Hirshman M.D. — ADDRESS (Street, city or town, state): 159 W Washington St Hagerstown Md — DATE SIGNED: 10/19/57

PHYSICIAN'S NAME (Type): Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 21 1957
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John R Watson Jr. — ADDRESS: Hagerstown Md
24a. REC'D BY REGISTRAR: Oct. 21. 1957
24b. REGISTRAR'S SIGNATURE: Chas H Boovers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11234

11198

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 4HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASH. Co. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 BOONSBORO
d. STREET ADDRESS: N. S. N. MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KIM Middle S. Last TOMS

4. DATE OF DEATH: Month OCT Day 28 Year 1957

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: OCT-27-1957
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): W-ONE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): WASH. CO. HOSPITAL HAGERSTOWN MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: KENNETH TOMS
14. MOTHER'S MAIDEN NAME: JANET VIRGINIA BOWARD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: KENNETH TOMS Address: BOONSBORO MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: --
762.5
DUE TO (b): Pulmonary atelectasis — --
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 27, 1957 to Oct. 28, 1957, that I last saw the deceased alive on Oct. 27, 1957, and that death occurred at 12:05A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: B B Kneisley M.D.
ADDRESS (Street, city or town, state): 148 West Washington St.
DATE SIGNED: 10/28/57

PHYSICIAN'S NAME (Type): B. B. Kneisley, M.D. Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Oct. 29. 1957
22c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY
22d. LOCATION (City, town, or county) (State): BOONSBORO WASH. Co. MD

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: BAST FUNERAL HOME BOONSBORO MD
24a. RECD BY REGISTRAR DATE: Oct. 29. 1957
24b. REGISTRAR'S SIGNATURE: Edward H Bowers

2081192XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11199

11235

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Rural - Hagerstown
d. STREET ADDRESS: RD 4 - Hagerstown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Clarence — Middle W. — Last Weaver

4. DATE OF DEATH: Month Oct — Day 1 — Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/10/1884
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Wash. Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Clarence Upton Weaver
14. MOTHER'S MAIDEN NAME: Elizabeth C. Blair

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. Annie Weaver — Address: RD4 Hagerstown, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/30/57, 19___, to 10/1/57 19___, that I last saw the deceased alive on 10/1/57, 19 57, and that death occurred at 7:20 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph F. Young M.D. — ADDRESS (Street, city or town, state): Williamsport, Md — DATE SIGNED: 10/3/57
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/4/57
22c. NAME OF CEMETERY OR CREMATORY: Broadfording
22d. LOCATION (City, town, or county) (State): Wash. Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: A.E. Munnich — ADDRESS: Greencastle Pa.
24a. REC'D BY REGISTRAR DATE: Oct. 3, 1957
24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11229

CERTIFICATE OF DEATH

Reg. Dist. No. 11236 302

1. PLACE OF DEATH
a. COUNTY: W shington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL Hagerstown
c. LENGTH OF STAY IN 1b: 5 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Hagerstown R.F.D. #1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL—Hagerstown
d. STREET ADDRESS: Hagerstown R.F.D. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Bessie; Middle: ; Last: Wells

4. DATE OF DEATH: Month: OCtober; Day: 25; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 17, 1871

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months: 7; Days: 7
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Small

14. MOTHER'S MAIDEN NAME: Rhoda Hicks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. William Wells
Address: Mt. View Trailer Court Hagerstown Md RFD #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/24/57, 19, to 10/25/57, 19, that I last saw the deceased alive on 10/25/57, 19, and that death occurred at 4:45 M from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph L. Young M.D.
ADDRESS (Street, city or town, state): Williamsport, Md
DATE SIGNED: 10/26/57
PHYSICIAN'S NAME (Type): Ralph L. Young

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 28, 1957
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Frederick, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Albert L. Zepp
ADDRESS: Williamsport, Md

24a. REC'D BY REGISTRAR DATE: OCT 29 1957
24b. REGISTRAR'S SIGNATURE: Chas. H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11200

CERTIFICATE OF DEATH

11237

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 7 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 1480 Jefferson Blvd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NORMAN — Middle FREDERICK — Last WHITMER

4. DATE OF DEATH: Month Oct — Day 1 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 22 1898

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Glass Blower

10b. KIND OF BUSINESS OR INDUSTRY: Neon Sign Co

11. BIRTHPLACE (State or foreign country): Waynesboro Franklin Co Pa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Fred J. Whitmer

14. MOTHER'S MAIDEN NAME: Esther Barnes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W. # 1

16. SOCIAL SECURITY NO.: 220-16-3546

17. INFORMANT: Mrs Elizabeth S. Whitmer — Address: 1480 Jefferson Blvd Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.
DUE TO
(b): Aortic Stenosis C — Years
DUE TO
(c): Decompensation

Conditions, if ony, which gave rise to immediate couse (o), stating the underlying couse last. 421.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 22, 1957, to 1 Oct, 1957, that I last saw the deceased alive on 1 Oct, 1957, and that death occurred at 10:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edwin S Hoagland M.D. — ADDRESS (Street, city or town, state): 115 W. Washington — DATE SIGNED: 10/2/57

PHYSICIAN'S NAME (Type): Edwin S Hoagland — Hagerstown Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct 3 1957

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Wash. Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR (Date): Oct 3 1957

24b. REGISTRAR'S SIGNATURE: Chas H Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed as required in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Ralph Young 11201 **CERTIFICATE OF DEATH**

11238

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 6 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 433 West Washington St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 1 433 West Washington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDNA Middle RUTH Last WINGERD

4. DATE OF DEATH: Month October Day 25 Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 23, 1886

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Penna Duffield, Franklin Co.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Wolf

14. MOTHER'S MAIDEN NAME: Alice Saum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): — — —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Roy B. Wingerd — Address: 560 Salem Ave.-Hagersto

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL Apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 10 Hr
DUE TO
334X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/24/57, 19___, to 10/25/57, 19___, that I last saw the deceased alive on 10/25/57, and that death occurred at 2 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph F. Young M.D. — ADDRESS (Street, city or town, state): William & Jack, M d — DATE SIGNED: 10/26/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-27-57

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown, Wash. Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman-Hagerstown, Maryland

24a. REC'D BY REGISTRAR: Oct. 28, 1957

24b. REGISTRAR'S SIGNATURE: Chas. H. Powers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and signed in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11202

11239

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 hour
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 28 E. Washington Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle LYDIA Last WOODYATT

4. DATE OF DEATH: Month October Day 26 Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: November 30, 1884
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months 10 Days 26
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Nevago, Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Marcus Leith
14. MOTHER'S MAIDEN NAME: Eliza Augerman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Blanche Durkee Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intestional obstruction — INTERVAL BETWEEN ONSET AND DEATH: 1 week
175X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Adenocarcinoma ovary with abdominal metastasis. — 8 months (history)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 5, 1957, to Oct. 26, 1957, that I last saw the deceased alive on October 23, 1957, and that death occurred at 10:15 A DST M, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Layman, M.D.
M.D. ADDRESS (Street, city or town, state): 100 Professional Arts Bldg. Hagerstown, Maryland
DATE SIGNED: 10-28-57
PHYSICIAN'S NAME (Type): William T. Layman, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/29/1957
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Suter-Rouzer Funeral Home R. Franklin Rouzer
ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR: Oct. 31 1957
24b. REGISTRAR'S SIGNATURE: Chas H Boewer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and signed in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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